

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT

08674

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08674

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form #M3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>		c. LENGTH OF STAY IN 1b <u>D. O. A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Avenue</u>		18-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Mary's Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Marion</u> Middle <u>Ray</u> Last <u>Bailey</u>				4. DATE OF DEATH Month <u>June</u> Day <u>21</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 26, 1902</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>21</u>	IF UNDER 24 HRS. Hours <u>19</u> Min. <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Winfield S. Maddox</u>				14. MOTHER'S MAIDEN NAME <u>Sadie Viola Curtin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>J. Lewis Bailey</u> Address <u>Avenue, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inter cranial damage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>116.5</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>immed</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Collision - auto &amp; bus</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>10:50</u> <u>6-21-67</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>RTS 234-238</u>		20f. (City or town) (County) (State) <u>Chopticon At Mary Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>W.D. Boyd</u>		EXAMINER'S NAME (Type) <u>William D. Boyd M.D.</u>		22. DATE SIGNED <u>6/21/67</u>		22. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 24, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Josephs</u>		23d. LOCATION (City or Town) (County) (State) <u>Morganza, Maryland</u>	
24. FUNERAL DIRECTOR <u>W. Clarke Mattingley</u> <u>Leonardtown, Maryland</u>				25a. REC'D BY REGISTRAR <u>JUN 26 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

08675

08675

1. PLACE OF DEATH a. COUNTY <b>ST. MARYS</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b> c. LENGTH OF STAY IN ID d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>ST. MARYS HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARYS</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>LEXINGTON PARK</b> d. STREET ADDRESS <b>BOX 237</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>PAUL EDISON BARNES</b>		First Middle Last		4. DATE OF DEATH <b>JUNE 10 1967</b>		Month Day Year	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/20/1919</b>	
9. AGE (in years last birthday) <b>48</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STOCK CLERK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CIVIL SERVICE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>J. EUGENE BARNES</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE C. EDGESTON</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>WW II 214 16 7166</b>		17. INFORMANT <b>MR. VICTOR H. BARNES - LEXINGTON PARK, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of pancreas with metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>157X</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5-18</b> , 19 <b>67</b> , to <b>6-10</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6-10</b> , 19 <b>67</b> , and that death occurred at <b>12:30 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>J. C. ROA M.D.</b>						22b. DATE SIGNED <b>6/11/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. ROA M.D.</b>						22d. ADDRESS <b>LEXINGTON PARK, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>6/12/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HOLY FACE CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>GREAT MILLS, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>JOHN M. WELCH</b>				25a. REC'D BY REGISTRAR <b>14 1967</b>		25b. REGISTRAR'S SIGNATURE <b>John M. Welch</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08676

08676

1. PLACE OF DEATH a. COUNTY <i>St. Mary's</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>St. Mary's</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Leonardtoun</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>St. Mary's Hospital</i>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <i>Rodney</i> Middle <i>Dickerson</i> Last <i>Dickerson</i>				4. DATE OF DEATH Month <i>June</i> Day <i>11</i> Year <i>1967</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Negro</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 8, 1962</i>	
9. AGE (In years lost birthday) <i>5</i> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>John H. Dickenson</i>				14. MOTHER'S MAIDEN NAME <i>Mary Louise Trent</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mother same as # 2 above</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchial Pneumonia</i> 5711 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Gastro-enteritis</i> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>June 7</i> , 19 <i>67</i> , to <i>June 11</i> , 19 <i>67</i> that (I) (we) last saw the deceased alive on <i>June 11</i> , 19 <i>67</i> , and that death occurred at <i>2 AM</i> , from causes and on the date stated above.							
22a. SIGNATURE <i>Charles Greenwell</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Charles Greenwell M. D.</i>				22d. ADDRESS <i>Leonardtoun, Maryland</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>May 6-13-67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Bushwood, Maryland</i>	
24. FUNERAL DIRECTOR <i>W. Clarke Mattingley</i>				ADDRESS <i>Leonardtoun, Maryland</i>		25a. REC'D BY REGISTRAR <i>JUN 14 1967</i>	
						25b. REGISTRAR'S SIGNATURE <i>Charles Young</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08677

CERTIFICATE OF DEATH

08677

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>		c. LENGTH OF STAY IN TB <u>7 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Mary's Hosp.</u>		d. STREET ADDRESS <u>Rt. 2 Box 115</u>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Jane</u> Last <u>Hebb</u>		4. DATE OF DEATH Month <u>June</u> Day <u>14</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 11, 1878</u>
9. AGE (In years lost birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>???</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Lue Ashton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Margaret L. Fenwick same as # 2 above</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>491X</u> IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> DUE TO (b) <u>Intestinal Virus, Hypertension</u> DUE TO (c) <u>Senility</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/14/67</u> , 19 <u>56</u> , to <u>June 14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>June 14</u> , 19 <u>67</u> , and that death occurred at <u>3 P.M.</u> from causes on and on the date stated above.			
22a. SIGNATURE <u>Charles Greenwell</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Charles Greenwell M.D.</u>		22d. ADDRESS <u>Leonardtown, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-16-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Aloysius</u>		23d. LOCATION (City or Town) (County) (State) <u>Leonardtown, Maryland</u>	
24. FUNERAL DIRECTOR <u>W. Clarke Mattingley Leonardtown, Maryland</u>		25. REG'D BY REGISTRAR <u>JUN 19 1967</u>	
26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		27. REGISTRAR'S NAME <u>Charles Judge</u>	

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*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "The", "and", "of", "in" are visible.]*



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08678

CERTIFICATE OF DEATH

08678

1. PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. MARY'S HOSPITAL</b>				d. STREET ADDRESS <b>LOVEVILLE</b>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>ARTHUR</b> Last <b>HOLT</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>2</b> Year <b>1967</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>COLORED</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 25, 1891</b>	9. AGE (In years lost birthday) yrs. <b>76</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSEPH ENDRES HOLT</b>				14. MOTHER'S MAIDEN NAME <b>MARY YOUNG</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>HELEN E. HOLT</b> Address <b>SAME AS #2 ABOVE</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerosis HD</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 15, 1966</b> , to <b>June 2, 1967</b> , that (I) (we) last saw the deceased alive on <b>June 1, 1967</b> , and that death occurred at <b>1 P.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>William D Boyd</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>6-5-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>WILLIAM D BOYD, M.D.</b>				22d. ADDRESS <b>LEONARDTOWN, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>6/5/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. JOSEPH'S</b>		23d. LOCATION (City or Town) (County) (State) <b>MORGANZA ST. MARY'S MD.</b>	
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY</b>				25a. REC'D BY REGISTRAR <b>LEONARDTOWN, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>f Charles Judge</b>	

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REPORT OF STATE

1. Name

2. Address

3. Date

4. Title

5. Subject

6. Object

7. Purpose

8. Method

9. Results

10. Conclusion

11. Remarks

12. Signature

13. Date

14. Title

15. Subject

16. Object

17. Purpose

18. Method

19. Results

20. Conclusion

21. Remarks

22. Signature

23. Date

24. Title

25. Subject

26. Object

27. Purpose

28. Method

29. Results

30. Conclusion

31. Remarks

32. Signature

33. Date

34. Title

35. Subject

36. Object

37. Purpose

38. Method

39. Results

40. Conclusion

41. Remarks

42. Signature

43. Date

44. Title

45. Subject

46. Object

47. Purpose

48. Method

49. Results

50. Conclusion

51. Remarks

52. Signature

53. Date

54. Title

55. Subject

56. Object

57. Purpose

58. Method

59. Results

60. Conclusion

61. Remarks

62. Signature

63. Date

64. Title

65. Subject

66. Object

67. Purpose

68. Method

69. Results

70. Conclusion

71. Remarks

72. Signature

73. Date

74. Title

75. Subject

76. Object

77. Purpose

78. Method

79. Results

80. Conclusion

81. Remarks

82. Signature

83. Date

84. Title

85. Subject

86. Object

87. Purpose

88. Method

89. Results

90. Conclusion

91. Remarks

92. Signature

93. Date

94. Title

95. Subject

96. Object

97. Purpose

98. Method

99. Results

100. Conclusion

101. Remarks

102. Signature

103. Date

104. Title

105. Subject

106. Object

107. Purpose

108. Method

109. Results

110. Conclusion

111. Remarks

112. Signature

113. Date

114. Title

115. Subject

116. Object

117. Purpose

118. Method

119. Results

120. Conclusion

121. Remarks

122. Signature

123. Date

124. Title

125. Subject

126. Object

127. Purpose

128. Method

129. Results

130. Conclusion

131. Remarks

132. Signature

133. Date

134. Title

135. Subject

136. Object

137. Purpose

138. Method

139. Results

140. Conclusion

141. Remarks

142. Signature

143. Date

144. Title

145. Subject

146. Object

147. Purpose

148. Method

149. Results

150. Conclusion

151. Remarks

152. Signature

153. Date

154. Title

155. Subject

156. Object

157. Purpose

158. Method

159. Results

160. Conclusion

161. Remarks

162. Signature

163. Date

164. Title

165. Subject

166. Object

167. Purpose

168. Method

169. Results

170. Conclusion

171. Remarks

172. Signature

173. Date

174. Title

175. Subject

176. Object

177. Purpose

178. Method

179. Results

180. Conclusion

181. Remarks

182. Signature

183. Date

184. Title

185. Subject

186. Object

187. Purpose

188. Method

189. Results

190. Conclusion

191. Remarks

192. Signature

193. Date

194. Title

195. Subject

196. Object

197. Purpose

198. Method

199. Results

200. Conclusion

201. Remarks

202. Signature

203. Date

204. Title

205. Subject

206. Object

207. Purpose

208. Method

209. Results

210. Conclusion

211. Remarks

212. Signature

213. Date

214. Title

215. Subject

216. Object

217. Purpose

218. Method

219. Results

220. Conclusion

221. Remarks

222. Signature

223. Date

224. Title

225. Subject

226. Object

227. Purpose

228. Method

229. Results

230. Conclusion

231. Remarks

232. Signature

233. Date

234. Title

235. Subject

236. Object

237. Purpose

238. Method

239. Results

240. Conclusion

241. Remarks

242. Signature

243. Date

244. Title

245. Subject

246. Object

247. Purpose

248. Method

249. Results

250. Conclusion

251. Remarks

252. Signature

253. Date

254. Title

255. Subject

256. Object

257. Purpose

258. Method

259. Results

260. Conclusion

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268. Method

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270. Conclusion

271. Remarks

272. Signature

273. Date

274. Title

275. Subject

276. Object

277. Purpose

278. Method

279. Results

280. Conclusion

281. Remarks

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287. Purpose

288. Method

289. Results

290. Conclusion

291. Remarks

292. Signature

293. Date

294. Title

295. Subject

296. Object

297. Purpose

298. Method

299. Results

300. Conclusion

301. Remarks

302. Signature

303. Date

304. Title

305. Subject

306. Object

307. Purpose

308. Method

309. Results

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME (5)  
SM 1/65

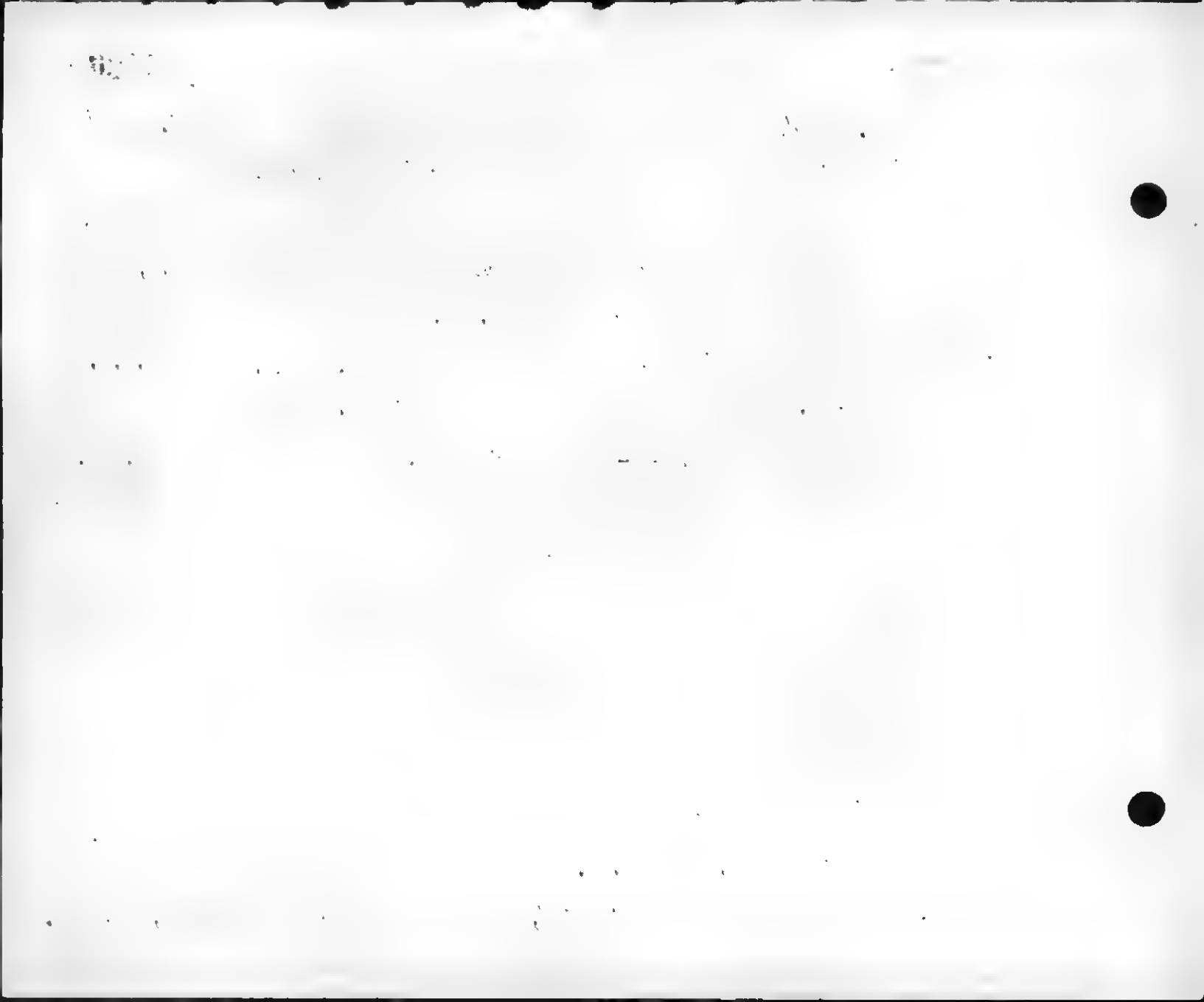
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08679

08679

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Mechanicsville</u> c. LENGTH OF STAY IN ID <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Mechanicsville</u> d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Boyd</u> Last <u>Hunter</u>		4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH <u>Aug. 17, 1899</u>		9. AGE (in years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance salesman</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David L. Hunter</u>		14. MOTHER'S MAIDEN NAME <u>Edith B. Mankel</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>214-344484</u>		17. INFORMANT <u>Edwin Slayman</u> Address <u>Box 88 Kingsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio-sclerotic HD</u> (c) <u>H200</u> DUE TO (b) <u>arterio-sclerotic HD</u> DUE TO (c) <u>H200</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>W. D. Boyd</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>6/17/67</u>	
EXAMINER'S NAME (Type) <u>William D. Boyd M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 20, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Millbill, Cemetery</u>	
23d. LOCATION (City, town or county) (State) <u>South Huntington, Penna.</u>					
24. FUNERAL DIRECTOR <u>C. Richard Mc Carley</u>		ADDRESS <u>9011 Line St. Nat. Rest. Co.</u>		25. REC'D BY REGISTRAR <u>June 29, 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08680

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08680

1. PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>LAWRENCE AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY MILDRED KNOTT</b>				4. DATE OF DEATH Month Day Year <b>JUNE 2 19 67</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 20, 1926</b>	
9. AGE (In years last birthday) <b>40</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WAITRESS</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>JESSIE CURRIE</b>				14. MOTHER'S MAIDEN NAME <b>PEARL BROWN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>213-22-0296</b>		17. INFORMANT <b>JOHN A KNOTT</b> Address <b>SAME AS #2 ABOVE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>William D Boyd MD</b> EXAMINER'S NAME (Type) <b>WILLIAM D BOYD MD</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>6/2/67</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>6/5/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. ALOYSIUS</b>		23d. LOCATION (City or Town) (County) (State) <b>LEONARDTOWN ST. MARY'S MD.</b>	
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY</b>				25a. REC'D BY REGISTRAR <b>LEONARDTOWN, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>William D Boyd</b>	

2500



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08681

CERTIFICATE OF DEATH

08681

1. PLACE OF DEATH a. COUNTY <b>St Marys</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) o STATE <b>Md.</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>				c. LENGTH OF STAY IN 1b <b>Rural-Hughesville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St Marys Hospital</b>				d. STREET ADDRESS <b>Rt 1 Box 142</b>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Koller</b> Last <b>Koller</b>				4. DATE OF DEATH Month <b>June</b> Day <b>26</b> Year <b>19 67</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Can.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-18-1886</b>		9. AGE (In years last birthday) <b>81</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Austria</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-36-5339</b>		17. INFORMANT <b>Willie Koller, Hughesville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO <b>IX</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 26</b> , 19 <b>63</b> , to <b>6/26</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6/24</b> , 19 <b>67</b> , and that death occurred at <b>6/26</b> , 19 <b>67</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Leon Barube</b>				22b. DATE SIGNED <b>6-27-67</b>		22c. PHYSICIAN'S NAME (Type) <b>Leon Barube</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>6-28-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St Marys Cemetery</b>	
23d. LOCATION (City or Town) <b>Bryantown, Charles, Md.</b>				23e. REC'D BY REGISTRAR <b>Charles Judge</b>		23f. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
24. FUNERAL DIRECTOR <b>The Hunt Funeral Home, Waldorf, Md.</b>				25. REC'D BY REGISTRAR <b>JUN 29 1967</b>			



1000

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08682

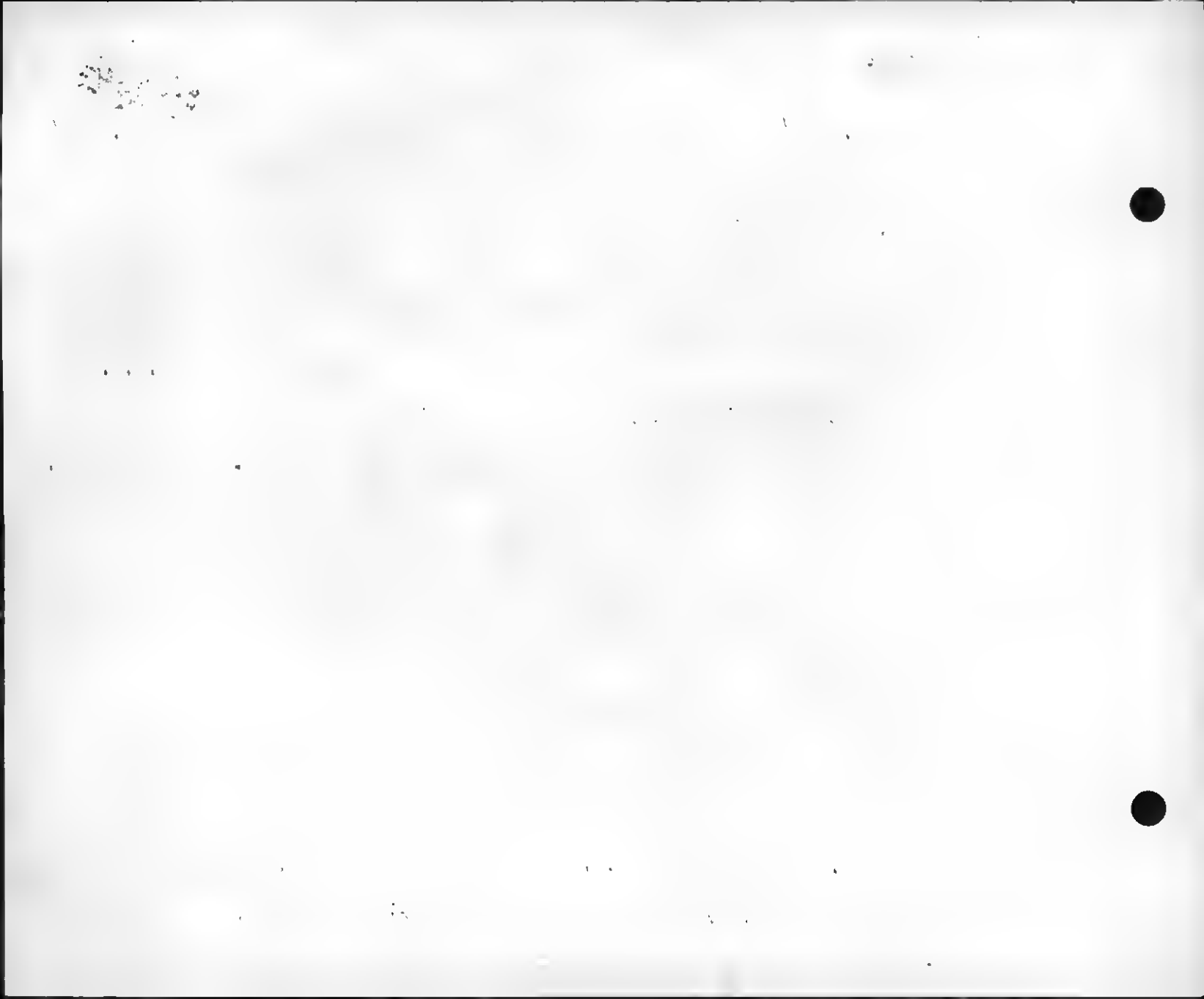
CERTIFICATE OF DEATH

08682

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission). a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>				c. LENGTH OF STAY IN 1b <u>73 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Mary's Hospital</u>				d. STREET ADDRESS <u>Rural Dameron</u>			
3 NAME OF DECEASED (Type or print) First <u>Helene</u> Middle <u>Elvira</u> Last <u>Linder</u>				4 DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1873</u> <u>6/6/1874</u>	9. AGE (In years last birthday) <u>93</u> yrs.	10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		11. IF UNDER 24 HRS Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Sweden</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Lars Frederick Hjelm</u>				14. MOTHER'S MAIDEN NAME <u>Wilhelmina Lebertau</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <u>XXXXXXXXXXXX</u>	17. INFORMANT <u>James E. Shea Dameron, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory Collapse</u> DUE TO (b) <u>Asphyxia of V. M. L.</u> DUE TO (c) <u>Dehydration &amp; Semility</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>11/7/67</u> <u>11/15/67</u> <u>11/15/67</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS A Topsy PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4/2</u> , 19 <u>67</u> to <u>6/15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/15</u> , 19 <u>67</u> , and that death occurred at <u>7:40</u> M., from causes and on the date stated above.							
22a. SIGNATURE <u>J. Patrick Jarboe</u> M.D.			22b. DATE SIGNED <u>6/15/67</u>		22c. PHYSICIAN'S NAME (Type) <u>J. Patrick Jarboe M.D.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>			23b. DATE THEREOF <u>June 16, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>
24. FUNERAL DIRECTOR <u>W. Clarke Mattingley</u>			ADDRESS <u>Leonardtown, Maryland</u>		25. REC'D BY REGISTRAR <u>JUN 19 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08683

CERTIFICATE OF DEATH

08683

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Maddox</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Maddox</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Boyd</u> <u>Walter</u> <u>Mayhew</u>		4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 24, 1898</u>
9. AGE (in years last birthday) <u>69</u> yrs		10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>15</u> Hours <u>8</u> Min <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales man</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Edwin Mayhew</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Harrison</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>213-10-7449</u>	
17. INFORMANT <u>Catherine V. Mayhew</u> Address <u>Maddox, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>am</u> <u>pm</u> <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> , to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>19</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>John F. Fenwick</u>		22b. DATE SIGNED <u>6-26-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John F. Fenwick M. D.</u>		22d. ADDRESS <u>Leonardtown, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June 26, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Christ Church Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Chaptico, Maryland</u>
24. FUNERAL DIRECTOR <u>W. Clarke Mattingley</u> <u>Leonardtown, Maryland</u>		25a. RECD BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08684

08684

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>		c. LENGTH OF STAY IN It <u>D. O. A.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Leonardtown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Mary's Hospital</u>		d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Magdalene</u> Last <u>Morgan</u>		4. DATE OF DEATH Month <u>June</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 21, 1889</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>19</u> Days <u>67</u>	11. IF UNDER 24 HRS. Hours <u>19</u> Min. <u>67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James H. Jones</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Spaulding</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Louis C. Morgan, Leonardtown, Maryland</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>10 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pernicious Anemia</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1963</u> to <u>June</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12 June 1967</u> , and that death occurred at <u>M</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Leon W. Berbue M. D.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Leon W. Berbue M. D.</u>		22d. ADDRESS <u>Mechanicville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 21, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Aloysius</u>		23d. LOCATION (City or Town) (County) (State) <u>Leonardtown, Maryland</u>	
24. FUNERAL DIRECTOR <u>W. Clarke Mattingley Leonardtown, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 26 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08685

CERTIFICATE OF DEATH

08685

1. PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL HOLLYWOOD</b>			c. LENGTH OF STAY IN It <b>LIFE</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL HOLLYWOOD,</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>BERNARDINE R. RALEY</b>				4. DATE OF DEATH Month Day Year <b>JUNE 28, 1967</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>OCT. 31, 1882</b>		9. AGE (in years last birthday) <b>84</b> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>HOLLYWOOD, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>STEPHEN E. RUSSELL</b>				14. MOTHER'S MAIDEN NAME <b>ALICE CECIL</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-36-6639</b>		17. INFORMANT Address <b>LAWRENCE Y. RALEY HOLLYWOOD, MARYLAND</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> <b>42222</b> DUE TO (b) <b>Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>Cerebral Hemorrhage</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1/16</b> , 1964 to <b>6/28</b> , 1967 that (I) (we) last saw the deceased alive on <b>6/28</b> , 1967, and that death occurred at <b>6A</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Charles Greenwell</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>CHARLES GREENWELL M. D.</b>				22d. ADDRESS <b>LEONARDTOWN, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>JUNE 30, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. JOHNS CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>HOLLYWOOD, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY</b>				ADDRESS <b>LEONARDTOWN, MARYLAND</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 10 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME (5)  
SM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08686		08686	
1. PLACE OF DEATH a. COUNTY <i>St. Mary's</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rural Chaptico</i> c. LENGTH OF STAY IN ID <i>MARYLAND</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>State Route 234 &amp; 238</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Camp Springs</i> d. STREET ADDRESS <i>5201 Middleton Lane</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Rose</i> Middle <i>Catherine</i> Last <i>Reed</i>	4. DATE OF DEATH Month <i>June</i> Day <i>21</i> Year <i>1967</i>	5. SEX <i>Female</i> 6. COLOR OR RACE <i>White</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <i>Oct. 11, 1900</i> 9. AGE (in years last birthday) <i>66</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i> 10b. KIND OF BUSINESS OR INDUSTRY <i>Peoples Life Ins</i>		11. BIRTHPLACE (State or foreign country) <i>Washington, D. C.</i> 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James S. Knott</i>		14. MOTHER'S MAIDEN NAME <i>Ann Laura Bailey</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes give war or dates of service)</i>		16. SOCIAL SECURITY NO. <i>Laura E. Suticello same as # 2 above</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Laceration of Spinal Cord</i> DUE TO (b) <i>Fracture cervical vert.</i> DUE TO (c) <i>"</i>		INTERVAL BETWEEN ONSET AND DEATH <i>immediate</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OF CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>collision auto + bus</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>6-31</i> p.m. <i>1967</i>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Rts 234-238</i>	20f. (City or town) (County) (State) <i>Chaptico St Marys Md</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>William D. Boyd M.D.</i>		22. DATE SIGNED <i>6/21/67</i>	
EXAMINER'S NAME (Type) <i>William D. Boyd M.D.</i>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>6-24-1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Resurrection</i>	23d. LOCATION (City, town or county) (State) <i>Prince George's Md</i>
24. FUNERAL DIRECTOR <i>Mattingley Funeral Home Leonardtown, Md.</i>		25a. REC'D BY REGISTRAR <i>JUN 23 1967</i> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

2020

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

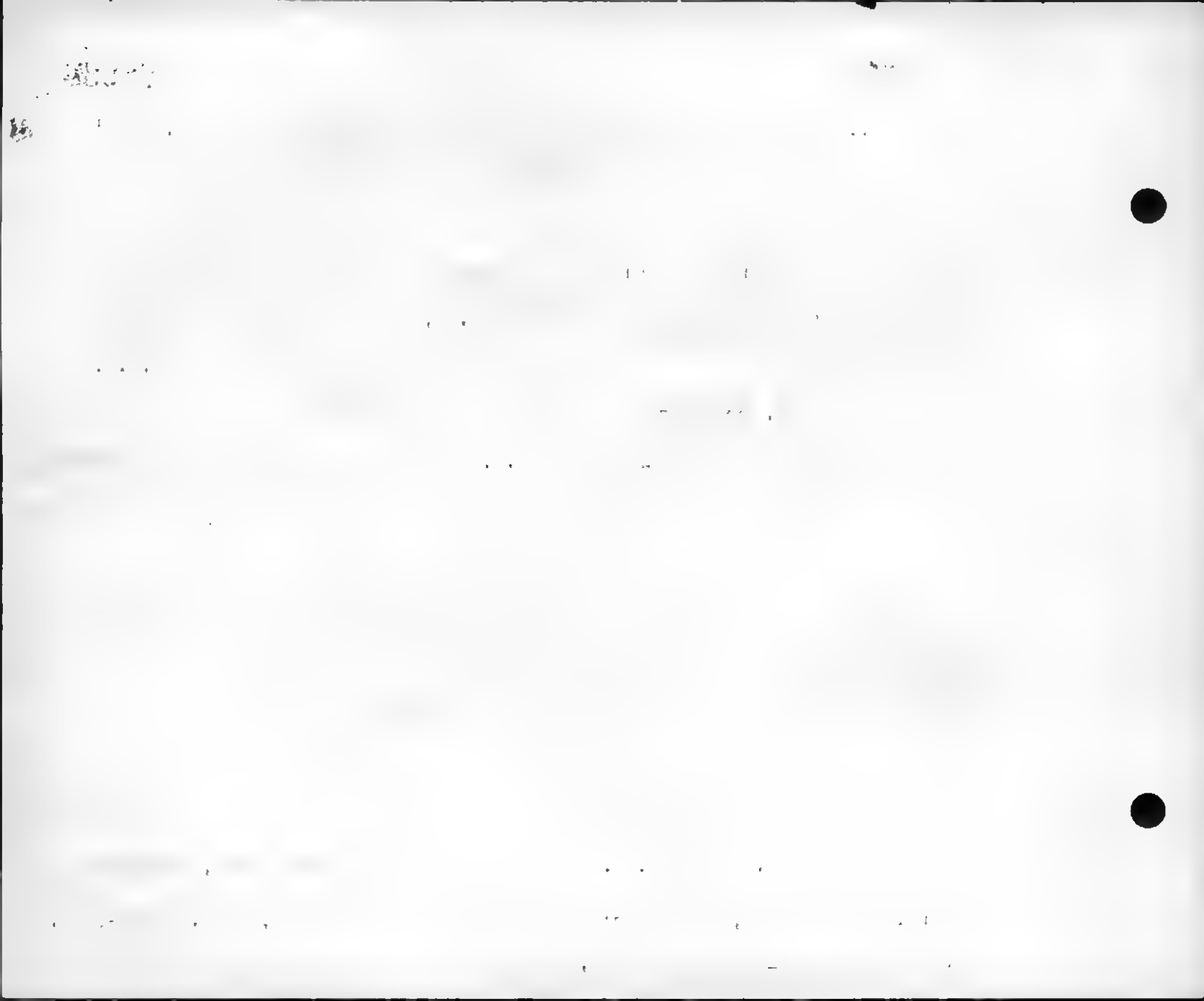
08687

08687

1. PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if instit. an Residence before admnssion) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL SCOTLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL SCOTLAND</b>	
c. LENGTH OF STAY IN 1b <b>26 YEARS</b>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JANIE FISH SAUNDERS</b>		4. DATE OF DEATH Month Day Year <b>JUNE 30, 1967</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 20, 1890</b>
9. AGE (in years last birthday) <b>77</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SANNER ALFRED G. SAUNDERS</b>		14. MOTHER'S MAIDEN NAME <b>ALICE FISH</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-3825495</b>	
17. INFORMANT <b>A.E. VERNON SAUNDERS</b>		Address <b>VALLEY LEE, MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial Infarction</b> DUE TO (c) <b>Coronary Artery Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>min</b> <b>min</b> <b>hrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1961</b> to <b>6/30, 1967</b> that (I) (we) last saw the deceased alive on <b>6/30 1967</b> , and that death occurred at <b>1 PM</b> from causes and on the date stated above			
22a. SIGNATURE <b>James P. Jarboe</b>		22b. DATE SIGNED <b>6/30/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JAMES P. JARBOE M. D.</b>		22d. ADDRESS <b>GREAT MILLS, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>JULY 2, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FRIENDSHIP CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>RIDGE, ST. MARY'S, MD.</b>
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY</b>		25a. REC'D BY REG. STRA. <b>JUL 10 1967</b>	
ADDRESS <b>LEONARDTOWN, MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

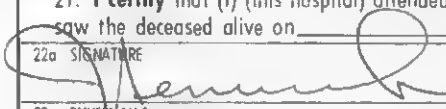

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The plate remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08688

CERTIFICATE OF DEATH

08688

1. PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN,</b> c. LENGTH OF STAY IN TB <b>6 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. MARY'S HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>AVENUE,</b> d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>FRANCIS</b> Last <b>THOMPSON</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>9</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 14, 1870</b>
9. AGE (In years last birthday) <b>97</b> yrs		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>20</b> Hours <b>0</b> Min. <b>0</b>	11. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMING</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES ALEXANDER THOMPSON</b>		14. MOTHER'S MAIDEN NAME <b>HARRIET MARJA RALEY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>217-36-6878A</b>	
17. INFORMANT <b>MRS PAUL MATTINGLY</b>		Address <b>LEONARDTOWN, MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Failure + Pneumonia</b> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Arteriosclerotic Heart Disease</b> (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>20 yr.</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from causes and on the date stated above			
22a. SIGNATURE 		22b. DATE SIGNED <b>6-12-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN F. FENWICK M. D.</b>		22d. ADDRESS <b>LEONARDTOWN, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>JUNE 12, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>BUSHWOOD, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLY</b>		25a. REC'D BY REGISTRAR <b>JUN 14 1967</b>	
25b. REGISTRAR'S SIGNATURE 			



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

08683

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08689

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>				c. LENGTH OF STAY IN 1b <u>1 hour</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Maddox</u> <u>18.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Mary's Hospital</u>				d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Stanton</u> Last <u>Weaver</u>				4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>19 67</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 31, 1922</u> <u>45</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>National Guard</u>		11. BIRTHPLACE (State or foreign country) <u>Madison, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Cleveland L. Weaver</u>				14. MOTHER'S MAIDEN NAME <u>Mary Saunders</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WWII</u>		16. SOCIAL SECURITY NO. <u>223 28 1100</u>		17. INFORMANT <u>Geraldine E. Weaver</u> Address <u>Maddox, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Coronary occlusion</u> DUE TO (b) <u>2</u> DUE TO (c) <u>2</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>William D. Boyd M. D.</u> M.D. EXAMINER'S NAME (Type) <u>William D. Boyd M. D.</u>				22. DATE SIGNED <u>6/12/67</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/15/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Bushwood, Maryland</u>	
24. FUNERAL DIRECTOR <u>W. Clarke Mattingley, Leonardtown, Maryland</u>				25a. REC'D BY REGISTRAR <u>JUN 14 1967</u> DATE 25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove, carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08690

08690

1. PLACE OF DEATH a. COUNTY <b>ST. MARYS</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b> c. LENGTH OF STAY IN Id d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. MARYS HOSPITAL</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARYS</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - CALIFORNIA</b> d. STREET ADDRESS <b>259 STAR RT.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>MINNIE N/M WIEBER</b>			4. DATE OF DEATH <b>JUNE 3 1967</b>		
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>8/30/1887</b>		9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>FREDERICK WEBER</b>		14. MOTHER'S MAIDEN NAME <b>ELISE REINECHE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213 05 3078D</b>		17. INFORMANT <b>MRS. ELSIE J. TEER SAME AS # 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cirrhosis of Liver</b> <b>581.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension and Heart failure.</b>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6-27-67</b> to <b>6-3-67</b> , that (I) (we) last saw the deceased alive on <b>6-3-67</b> 19, and that death occurred at <b>1 A</b> M, from the causes and on the date stated above.					
22a. SIGNATURE <b>W.H. Patrick</b>			22b. DATE SIGNED <b>6/3/67</b>		
22c. PHYSICIAN'S NAME (Type) <b>W. H. PATRICK M.D.</b>			22d. ADDRESS <b>LEXINGTON PARK, MARYLAND</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>6/5/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN CEMETERY</b>	
23d. LOCATION (City, town or county) (State) <b>BALTO. CO. MARYLAND</b>		24. FUNERAL DIRECTOR <b>John M. Welch</b>		25a. REC'D BY REGISTRAR <b>JUN 7 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. ADDRESS <b>LEONARDTOWN, MD.</b>			

08030

08030